

4000092

Damaged Document(s)

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BUREAU OF VITAL STATISTICS		ARIZONA STATE BOARD OF HEALTH		STANDARD CERTIFICATE OF DEATH	
1. PLACE OF DEATH				State File No. <u>81</u>	
County <u>Gila</u>		State _____		Registered No. <u>131</u>	
District or Township _____		or Village _____		or _____	
City <u>Miami</u>		No. _____		St. _____ Ward _____	
(If death occurred in a hospital or institution, give its NAME instead of street and number).					
2. FULL NAME <u>Walter Leo Layton</u>					
(a) Residence No. <u>Lower Miami</u>		St. _____		Ward _____	
(Usual place of abode) (If non-resident, give city or town and State)					
Length of residence in city or town where death occurred		yrs.	mos.	ds.	How long in U. S. if of foreign birth? yrs. mos. ds.
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX	4. COLOR or RACE	5. SINGLE, MARRIED, WIDOWED or DIVORCED.			
<u>Male</u>	<u>White</u>	<u>Single</u>			
6a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____					
6. DATE OF BIRTH (month, day and year) <u>Mar. 1905</u>					
7. AGE	Years	Months	Days	IF LESS than 1 day _____ hrs. or _____ min.	
<u>22</u>					
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Flagman in mine</u>					
(b) General nature of industry, business or establishment in which employed (or employer) _____					
(c) Name of employer _____					
9. BIRTHPLACE (city or town) (State or country) <u>Arizona</u>					
10. NAME OF FATHER <u>A. T. Layton</u>					
11. BIRTHPLACE OF FATHER (State or country) <u>Utah</u> (city or town) _____					
12. MAIDEN NAME OF MOTHER <u>A. Gibbs</u>					
13. BIRTHPLACE OF MOTHER (State or country) <u>Utah</u> (city or town) _____					
14. Informant <u>A. T. Layton</u>					
(Address) <u>London, Ariz.</u>					
15. Filed <u>June 20, 1927</u> <u>L. B. Dinn</u> Registrar.					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>6</u> <u>18</u> <u>1927</u>					
Month Day Year					
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____					
that I last saw him _____ alive on _____, 19____					
and that death occurred, on the date stated above, at <u>430 p.m.</u>					
The CAUSE OF DEATH* was as follows:					
<u>Fractured skull, hemorrhage and shock from being run over by ore train</u>					
<u>no level of inspiration shown</u>					
(duration) _____ yrs. _____ mos. _____ ds.					
CONTRIBUTORY (Secondary) _____					
(duration) _____ yrs. _____ mos. _____ ds.					
18. Where was disease contracted if not at place of death? _____					
Did an operation precede death? _____ Date of _____					
Was there an autopsy? _____					
What test confirmed diagnosis? _____					
(Signed) <u>[Signature]</u> (Address) _____					
* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)					
19. PLACE OF BURIAL, CREMATION OR REMOVAL <u>Tumacac, Ariz</u>				DATE OF BURIAL <u>6/21/27</u>	
20. UNDERTAKER <u>J. Ray Miles</u>				ADDRESS <u>Miami</u>	